Washington State Department of Social & Health Services

MEDICAL DISABILITY DECISION

DSHS 14-144A

INSTRUCTIONS

The Medical Disability Decision form, DSHS 14-144A, is a report of a client's disability, medical evidence, and work history sent to the Division of Disability Determination Service (DDDS) for medical disability determination.

The Service Worker initiates the DSHS 14-144A. The Service Worker should ensure that the Worker's name, Community Service Office (CSO), and telephone number are noted on the form.

NOTE TO THE SERVICE WORKER: Route the original to DDS and place in the service file when returned.

1. The Service Worker completes the heading to indicate the name, Social Security Number (SSN), and disabling condition of the client.

2. The Service Worker may assist the client complete Part I - Information About Your Condition. Dates need not be exact, but should reflect month and year.

3. The Service Worker may assist the client complete Part II - Information About Your Medical Records. It is important to identify physicians and treatment sources as completely as possible.

4. The Service Worker may assist the client complete Part III - Information About Your Activities. The Service Worker should review information to ensure client's limitations are clearly identified.

5. The Service Worker may assist the client complete Part IV- Information About Your Education. It should be noted if school classes were Special Education classes.

6. The Service Worker may assist the client complete Part V - Information About the Work You Did. Individual employers should not be listed, only the type of business.

Washington State Department of Social & Health Services

DISABILITY REPORT

MEDICAL DISABILITY DECISION

This form is completed by a social services worker during an interview with the claimant or claimant's representative. **Please print, type, or write clearly and answer all items to the best of your ability.** Answer all questions. **Complete answers help process the claim.** *If you need more space to answer any of the questions in this form, attach additional sheets.*

1. CLAIMANT'S NAME	2. SOCIAL SECURITY NUMBER	3. TELEPHONE NUMBER (INCLUDE AREA CODE)

4. WHAT IS YOUR DISABLING CONDITION? BRIEFLY EXPLAIN THE INJURY OR ILLNESS THAT STOPS YOU FROM WORKING.

PART 1. INFORMATION ABOUT YOUR CONDITION

1. What date did your condition first bother you? _____ (MONTH DAY YEAR)

	YES	NO
2A. Did you work after the date shown in item 1 above? *If you answer no, go to 3A. and 3B. below.*	☐	☐
2B. **If you answered yes to 2A.**, did your condition cause you to change:		
Your job or job duties?	☐	☐
Your hours of work?	☐	☐
Your attendance?	☐	☐
Anything else about your work?	☐	☐

2C. **If you answered yes to any item in 2B.,** explain what the changes in your work circumstances were, the dates they occurred, and how your condition made these changes necessary:

3A. When did your condition finally make you stop working? _____ (MONTH DAY YEAR)

3B. Explain how your condition now keeps you from working:

PART 2. INFORMATION ABOUT YOUR MEDICAL RECORDS

1. Enter the following information about the doctor who has the latest medical records about your disabling condition:

Check here if the claimant has NO doctor. ☐

DOCTOR'S NAME	3. TELEPHONE NUMBER (INCLUDE AREA CODE)	HOW OFTEN DO YOU SEE THIS DOCTOR?
ADDRESS		DATE YOU FIRST SAW THIS DOCTOR
ILLNESS OR INJURY FOR WHICH YOU HAD AN EXAMINATION OR TREATMENT		DATE YOU LAST SAW THIS DOCTOR

TYPE OF TREATMENT OR MEDICINES RECEIVED (I.E., SURGERY, CHEMOTHERAPY, RADIATION, AND THE MEDICINES YOU TAKE FOR YOUR ILLNESS OR INJURY, IF KNOWN. IF NO TREATMENT OR MEDICINES, WRITE NONE.

2. Have you seen any other doctors since your disabling condition began? ☐ Yes ☐ No **If yes, answer the following.**

DOCTOR'S NAME	3. TELEPHONE NUMBER (INCLUDE AREA CODE)	HOW OFTEN DO YOU SEE THIS DOCTOR?
ADDRESS		DATE YOU FIRST SAW THIS DOCTOR
ILLNESS OR INJURY FOR WHICH YOU HAD AN EXAMINATION OR TREATMENT		DATE YOU LAST SAW THIS DOCTOR

TYPE OF TREATMENT OR MEDICINES RECEIVED (I.E., SURGERY, CHEMOTHERAPY, RADIATION, AND THE MEDICINES YOU TAKE FOR YOUR ILLNESS OR INJURY, IF KNOWN. IF NO TREATMENT OR MEDICINES, WRITE NONE.

If you have seen additional doctors since this illness or injury, attach additional pages with the above information.

PART 2. INFORMATION ABOUT YOUR MEDICAL RECORDS (CONTINUED)

3. Have you been hospitalized or treated at a clinic for your disabling condition? ☐ Yes ☐ No **If yes, answer the following.**

NAME OF HOSPITAL OR CLINIC	ADDRESS
PATIENT OR CLINIC NUMBER	

Were you an inpatient (stayed at least one night)?
☐ Yes ☐ No **If yes, answer the following.**

PATIENT OR CLINIC NUMBER	PATIENT OR CLINIC NUMBER

Were you an outpatient? ☐ Yes ☐ No
If yes, what were the dates of your visits?

ILLNESS OR INJURY FOR WHICH YOU HAD AN EXAMINATION OR TREATMENT

TYPE OF TREATMENT OR MEDICINES RECEIVED (I.E., SURGERY, CHEMOTHERAPY, RADIATION, AND THE MEDICINES YOU TAKE FOR YOUR ILLNESS OR INJURY, IF KNOWN. IF NO TREATMENT OR MEDICINES, WRITE NONE.

4. If you have been in other hospital or clinic for your illness or injury, answer the following:

NAME OF HOSPITAL OR CLINIC	ADDRESS
PATIENT OR CLINIC NUMBER	

Were you an inpatient (stayed at least one night)?
☐ Yes ☐ No **If yes, answer the following.**

PATIENT OR CLINIC NUMBER	PATIENT OR CLINIC NUMBER

Were you an outpatient? ☐ Yes ☐ No
If yes, what were the dates of your visits?

ILLNESS OR INJURY FOR WHICH YOU HAD AN EXAMINATION OR TREATMENT

TYPE OF TREATMENT OR MEDICINES RECEIVED (I.E., SURGERY, CHEMOTHERAPY, RADIATION, AND THE MEDICINES YOU TAKE FOR YOUR ILLNESS OR INJURY, IF KNOWN. IF NO TREATMENT OR MEDICINES, WRITE NONE.

If you have been in other hospitals or clinics for your illness or injury, list the names, addresses, patient or clinic numbers, dates and reasons in Part 6. or attach additional pages.

5. Have you had any of the following tests in the last year? Check the appropriate box below and, you answer "yes," give where and when the test was done.

TEST	YES	NO	WHERE DONE	WHEN DONE
Electrocardiogram	☐	☐		
Chest X-ray	☐	☐		
Other X-ray (specify type):	☐	☐		
Breathing tests	☐	☐		
Blood tests	☐	☐		
Other (specify):	☐	☐		

6. If you have a Medicaid card, what is your number: _____

PART 3. INFORMATION ABOUT YOUR ACTIVITIES

1. Has your doctor told you to cut back or limit your activities in any way? ☐ Yes ☐ No
If yes, give the name of the doctor below and tell what he or she told you about cutting back or limiting your activities.

PART 3. INFORMATION ABOUT YOUR ACTIVITIES (CONTINUED)

2. Describe your daily activities in the following areas and state what and how much you do of each and how often you do it.

- Household maintenance (including cooking, cleaning, shopping, and odd jobs around the house)
- Recreational activities and hobbies (hunting, fishing, bowling, hiking, musical instruments, etc.)
- Social contacts (visits with friends, relatives, neighbors)
- Other (drive care, motorcycle, ride bus, etc.)

PART 4. INFORMATION ABOUT YOUR EDUCATION

1. What is the highest grade of school that you completed? _____ What year? _____
2. Have you gone to trade or vocational school or had any type of special training? ☐ Yes ☐ No **If yes, answer the following.**

TYPE OF TRADE OR VOCATIONAL SCHOOL OR TRAINING	APPROXIMATE DATES YOU ATTENDED

HOW THIS SCHOOLING OR TRAINING WAS USED IN ANY WORK YOU DID

PART 5. INFORMATION ABOUT THE WORK YOU DID

1. List all jobs you have had in the last 15 years before you stopped working, beginning with your usual job. This means the kind of work you did the longest. If you have 6th grade education or less, AND did only heavy unskilled labor for 35 years or more, list all of the jobs you have had since you began to work. If you need more space, either attach additional pages or use Part 6.

JOB TITLE	TYPE OF BUSINESS	FROM	TO	DAYS PER WEEK	RATE OF PAY (PER HOUR, DAY, WEEK, MONTH, OR YEAR)

2A. In your usual job listed above, did you:

	YES	NO
Use machines, tools, or equipment of any kind?	☐	☐
Use technical knowledge or skills?	☐	☐
Do any writing, complete reports, or perform similar duties?	☐	☐
Have supervisory responsibilities?	☐	☐

2B. Explain all yes answers by giving a full description of: the types of machines, tools, or equipment you used and the exact operation you performed; the technical knowledge or skills involved; the type of writing you did, and the nature of any reports; and the number of people you supervised and the extent of your supervision.

PART 5. INFORMATION ABOUT THE WORK YOU DID (CONTINUED)

2C. Describe the kind and amount of physical activity your usual job involved during a typical day by checking the best answer below.

How many hours a day did you:

	0	1	2	3	4	5	6	7	8
Walk?	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stand?	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sit?	☐	☐	☐	☐	☐	☐	☐	☐	☐

How often a day did you:

	Never	Occasionally	Frequently	Constantly
Bend?	☐	☐	☐	☐
Reach?	☐	☐	☐	☐

Lifting and carrying: describe what was lifted and how far it was carried.

What was the heaviest weight you lifted? ☐ 10 lbs. ☐ 20 lbs. ☐ 50 lbs. ☐ 100 lbs. ☐ Over 100 lbs.

What was the weight you frequently lifted or carried? ☐ Up to 10 lbs. ☐ Up to 25 lbs. ☐ Up to 50 lbs. ☐ Over 50 lbs.

PART 6. REMARKS

1. Use this section for additional space to answer any previous questions. Also use this space to give any additional information that you think will be helpful in making a decision in your disability claim (such as information about other illnesses or injuries not listed previously).

	YES	NO
2. Does the claimant speak English? If no, what language does he/she speak:	☐	☐
3. Does the claimant need assistance processing his or her claim?	☐	☐

If yes, give the name, relationship, and telephone number of a person willing to assist the claimant.

4. Can the claimant (or the claimant's representative) be readily reached by telephone with no communication problems due to language, speech or hearing difficulties?	☐	☐	

5. Check which difficulties below, if any, were observed while interviewing the claimant.

☐ Reading	☐ Writing	☐ Answering questions	☐ Hearing
☐ Sitting	☐ Understanding	☐ Using hands	☐ Breathing
☐ Seeing	☐ Walking	☐ Other (specify):	

If any of the above items were checked, describe the exact difficulty involved:

6. Describe the claimant fully (e.g., general build, height, weight, behavior, any difficulties that add to or supplement those noted above):

SOCIAL SERVICE WORKER'S SIGNATURE	DATE	TITLE